Shrewsbury Public Schools

Summer Program/Emergency Information Form

Last Name | First Name | Full Middle Name | Home Phone | Gender

Street | Current SPS student (Y/N) | Birth date | Guardianship

Emergency Contacts:

Mother | Mother's Home Phone # | Mother Cell Phone | Mother's Employer | (Work) Phone

Mother's Address | Mother's City, State, Zip

Father | Father's Home Phone# | Father Cell Phone | Father's Employer | (Work) Phone

Father's Address | Father's City, State, Zip

If other than parent: Legal Guardian First Name | If other than parent: Legal Guardian Last Name | Guardian Home # | Guardian Cell # | Work #

Contacts 1 and 2 are, in most cases, friends or relatives who are willing to take responsibility for the student in case of illness or emergency.

Contact 1 | Relationship | Contact 1 Home # | Contact 1 Cell # | Contact 1 Work #

Contact 2 | Relationship | Contact 2 Home # | Contact 1 Cell # | Contact 2 Work #

Mother's E-Mail _____ Father's E-Mail _____

Physician _____ Physician Phone _____

Please list Medicare Plan and Identification Number (if applicable)_____

Please contact the school nurse if you need assistance obtaining medical insurance.

1. **If there is a medical condition that the school should be aware of, please contact the nurse.**
2. I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs.
3. I give permission to the school nurse to treat and arrange emergency transport for my child as needed.
4. The federal government has ruled schools can be reimbursed through Medicaid for special education services. I give permission to use the students Mass Health Card # to bill for the special education services rendered.

Signature of Parent/Guardian _____

STUDENT HEALTH HISTORY

Date: _____ Grade: _____

Student Name: _____ D.O.B.: _____

Parent/Guardian: _____ Phone: _____

Address: _____

Primary Physician's Name: _____

List any operations, fractures, sprains or bone dislocations: (Date or Age):

_____ _____

_____ _____

Reason: _____

_____

Has your child ever had any of the following? Please circle Y-for yes or N-for no.

Asthma and/or Allergies	Y	N	Mononucleosis	Y	N
Fainting and/or Convulsions	Y	N	Hepatitis	Y	N
Rheumatic Fever	Y	N	Bronchitis	Y	N
Kidney Disease/Injury	Y	N	Head Injury	Y	N
Heat Stroke/Heat Exhaustion	Y	N	Concussion	Y	N
Diabetes	Y	N	Seizure	Y	N
Menstrual Disorders	Y	N	Serious Dental Problems	Y	N
Blood Disorders	Y	N	Tumors	Y	N

If YES to any of the above, please explain: _____

_____

_____

Are there any other serious illnesses or injuries? _____

Does your child take any medications now (prescription and/or "over the counter")? _____

If so: Name(s), Dose & Frequency? _____

I give my permission to the school nurse to administer the following medications/treatments per label directions.
Acetaminophen (Tylenol), Ibuprofen, Bacitracin, Hydrocortisone Cream 1%, and Calamine/Caladryl.

_____ I agree that the school nurse may give my child all of the above medications/treatments.

_____ School Nurse may administer all of the above medications/treatments except for: _____

***If your child requires medication during the summer school day, please have your physician complete the Shrewsbury Public Schools "Medication Order" Form, also available on the website.

Parent Signature: _____ **Date:** _____